

U.S. Department of Labor

Office of Administrative Law Judges
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DATE ISSUED: December 21, 2000

CASE NO. 2000-BLA-469

In the Matter of

LUTHER A. BLANKENSHIP, (Deceased)
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Michael E. Bevers, Esq.,
For the Claimant

Douglas A. Smoot, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a petition for a modification of a claim for benefits, under the Black

Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (“Act”), filed on November 21, 1996. (DX 1).¹ The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis (“black lung disease” or “coal workers pneumoconiosis” “CWP”) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first claim for benefits on February 8, 1977. (DX 24-22). On September 26, 1977, the claim was denied because the evidence failed to establish the elements of entitlement. (DX 24-22). By letter dated December 10, 1979, the claim was denied due to abandonment. (DX 24-22).

Claimant filed a second claim for benefits on June 17, 1983. (DX 24-1). On February 8, 1985, the claims examiner denied benefits because claimant failed to establish he was totally disabled due to pneumoconiosis. (DX 24-13). On July 26, 1985, the claim was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was subsequently postponed. (DX 24-49). On December 19, 1989, Judge Gray remanded the case to the District Director. (DX 24-52). The case was referred to the Office of Administrative Law Judges for a formal hearing on May 18, 1990. (DX 24-63).

A hearing was held on October 23, 1990 before Judge Amery. (DX 24-69). By Decision and Order dated April 18, 1991, Judge Amery found claimant had CWP arising out of coal mine employment but found claimant had not established total disability due to the disease. (DX 24-71). Claimant appealed and on April 22, 1992, the Benefits Review Board affirmed Judge Amery’s decision. (DX 24-77).

Claimant filed his third living miner’s claim on May 23, 1994. (DX 25-1). On November 7, 1994, the claims examiner denied benefits. (DX 25-18). On May 24, 1995, the district director issued a letter finding the claim abandoned. (DX 25-23).

¹ The following abbreviations are used for reference within this opinion: DX-Director’s Exhibits; CX- Claimant’s Exhibit; EX- Employer’s Exhibit; TR- Hearing Transcript; Dep.- Deposition.

Claimant filed his fourth claim on November 21, 1996. (DX 1). On February 5, 1997, the claim was denied by the district director because the evidence failed to establish a material change in conditions or that claimant was totally disabled by CWP. (DX 12). On April 21, 1997, the claimant requested a hearing before an administrative law judge. (DX 13). On June 30, 1997, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. (DX 26). On August 18, 1998, Judge Sarno issued a Decision and Order Denying Benefits, finding claimant did not establish a material change in conditions. (DX 48).

On May 19, 1999, counsel for claimant submitted a letter disagreeing with Judge Sarno's decision, stating he wished to pursue the black lung claim, and requested the claim file. (DX 49). By letter dated May 27, the claims examiner stated that claimant had until August 18, 1999 to request a modification. (DX 50). By letter dated August 17, 1999, the claims examiner granted claimant an additional 30 days to request a modification due to the delay in sending the claim file. (DX 51). By letter dated September 22, 1999, claimant submitted a petition for modification. (DX 52). On December 20, 1999, the district director issued a Proposed Decision and Order Granting Modification and finding claimant totally disabled due to pneumoconiosis. (DX 57). By letter dated January 17, 2000, the employer requested a formal hearing. (DX 59). On January 31, 2000, the district director informed claimant would be paid by the Black Lung Disability Trust Fund. (DX 60). The case was referred to the Office of Administrative Law Judges on February 16, 2000. (DX 62). I was assigned the case on April 12, 2000.

On August 15, 2000, I held a hearing in Abingdon, Virginia, at which the claimant and employer were represented by counsel.² No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-3, Director's exhibits ("DX") 1-63, and Employer's exhibits ("EX") 1-13 were admitted into the record.

Post-hearing evidence consists of EX 14, an August 17, 2000 report from Dr. Castle, and EX 15, deposition testimony of Dr. Castle taken on September 25, 2000.

ISSUES

- I. Whether the miner is totally disabled?
- II. Whether the miner's disability is due to pneumoconiosis?
- III. Whether claimant filed a timely modification claim?

² Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust is determinative of the circuit court's jurisdiction.

- IV. Whether there has been a mistake of fact or material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner

I find, and agree with Judge Amery's finding, that based on claimant's social security records that claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 26.25 years.

B. Date of Filing³

The claimant filed his claim for benefits, under the Act, on November 21, 1996. (DX 1). On August 18, 1998, Judge Sarno issued a Decision and Order Denying Benefits. (DX 48). On May 19, 1999, counsel for claimant submitted a letter disagreeing with Judge Sarno's decision, stating he wished to pursue the black lung claim, and requested the claim file. (DX 49). By letter dated May 27, 1999, the claims examiner stated that claimant had until August 18, 1999 to request a modification. (DX 50). By letter dated August 17, 1999, the claims examiner granted claimant an additional 30 days to request a modification due to the delay in sending the claim file. (DX 51). By letter dated September 22, 1999, claimant submitted a petition for modification. (DX 52).

Employer argues that claimant did not file a timely modification claim. Any communication, no matter how informal, may serve as a request for modification. In *Cobb v. Schirmer Stevedoring Co.*, 2 B.R.B.S. 132 (1975), *aff'd*, 577 F.2d 750 (9th Cir. 1978), a phone call from the claimant which is memorialized by the District Director, wherein the claimant stated that he was dissatisfied with his compensation, was held to be a sufficient request for modification. "[T]he modification procedure is flexible, potent, easily invoked, and intended to secure 'justice under the act.'" "Almost any sort of correspondence from the claimant can constitute a request for modification of a denial, as long as it is timely and expresses dissatisfaction with a purportedly erroneous denial." *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, Case No. 98-2731 (4th Cir. Oct. 21, 1999).

³ 20 C.F.R. §725.310 (For Modifications) provides:

(a) . . .the director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

I find claimant's May 19, 1999 letter sufficient to constitute a request for modification within one year from the previous denial, issued by Judge Sarno on August 18, 1998. Thus, claimant filed a timely modification claim.

C. Responsible Operator

Island Creek Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F, Part 25 of the Regulations. (TR 10).

D. Dependents⁴

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife. (TR 9).

E. Personal, Employment, and Smoking History

The claimant was born on May 30, 1927. (TR 28). He married Ada on July 7, 1975. (DX 24-22). He last worked in the coal mines at Island Creek for seven years. The claimant's last position in the coal mines was that of a "stoper." (TR 29). Claimant would drill into the roof of the mine and was required to set up the machine, which weighed 90 pounds, several times a day. (TR 30). Claimant also had to carry a heavy hose. (TR 31). Claimant was exposed to dust as the stoper drilled into the roof of the mine. (TR 32). Claimant testified that he stopped smoking in the 1970's. Claimant does not perform any physical activity during a normal day. (TR 32).

Mrs. Blankenship testified at the hearing. (TR 35). Mrs. Blankenship testified that she has been married to the claimant since 1975. (TR 36). She testified that she accompanied her husband to his examination with Dr. Castle. (TR 36). Mrs. Blankenship stated that she and her husband had to wait over two hours before the examination. (TR 37). Claimant's treating physician is Dr. Forehand. (TR 38).

Kenneth Holbrook testified at the hearing. (TR 40). Mr. Holbrook testified that he operated a stoper for two or three years. A stoper is a machine similar to a jack hammer. (TR 41). Mr. Holbrook agreed that a stoper weighs around 90 pounds. The stoper drilled holes in the roof for bolting. (TR 42). A roof bolter would be required to carry bags of rock dust and timbers. Mr. Holbrook testified that bag normally weighed fifty pounds. (TR 43). Mr. Holbrook testified that the

⁴ See 20 C.F.R. §§ 725.204-725.211.

timbers could weigh between 25 to 100 pounds. Mr. Holbrook testified that the stoper job required extremely heavy labor. (TR 44). Mr. Holbrook did not work with Mr. Blankenship. (TR 45).

II. Medical Evidence

I incorporate by reference the summary of evidence contained in Judge Sarno's Decision and Order Denying Benefits dated August 18, 1998 and Amery's Decision and Order Denying Benefits dated April 11, 1991. (DX 48; DX 24-71). The following is a summary of the evidence submitted since the previous denial.

A. Chest X-rays

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualifi c-ations	Film Qual ity	ILO Classif ication	Interpretation or Impression
DX 54	08-03-99 08-03-99	Forehand	B	2	1/0	p/p in six zones.
CX 2	08-03-99 08-04-99	Nasreen	BCR			Chronic interstitial lung markings, stable since 5/12/97.
DX 56	08-03-99 11-29-99	Hippensteel	B	1	1/1	p/q small opacities in six zones; arteriosclerosis of the aorta.
DX 56	11-03-99 11-03-99	Hippensteel	B	2	1/1	p/q small opacities in six zones; arteriosclerosis of the aorta.
CX 2	07-14-00 07-14-00	Forehand	B		1/2	p/p, diffuse reticular nodular interstitial lung disease.

* A- A-reader; B- B-reader; BCR- Board-certified radiologist. Readers who are Board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))(en banc)(Unpublished). If no categories are chosen, in box 2B(c) of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies

Pulmonary Function Tests are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	Age Height	FEV ₁	MVV	FVC	Tracings	Comprehension Cooperation	Qualify	Dr.'s Impression
Forehand 08-03-99 DX 54	72 69"	3.31		4.28	Yes		No	
Hippenseel 11-03-99 DX 56	72 70"	3.06 2.58+	46	4.58 4.61+	Yes	Poor Fair	No No+	Unable to complete lung volume, effort fair.
Forehand 07-14-00 CX 2	73 69"	4.25	28	4.52	Yes		No	

* A “**qualifying**” pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study “**conforms**” if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

For a miner of the claimant’s height of 69" inches, § 718.204(c)(1) requires an FEV₁ equal to or less than 1.79 for a male 73 years of age.⁵ If such an FEV₁ is shown, there must be in addition, an FVC equal to or less than 2.31 or an MVV equal to or less than 72; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV₁/FVC ratio requirement remains constant.

⁵ The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protapappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are “qualifying.” *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 69" here, the most often reported height.

Height	Age	FEV ₁	FVC	MVV
69"	72	1.79	2.31	72
70"	72	1.88	2.43	75
69"	73	1.79	2.31	72

C. Arterial Blood Gas Studies⁶

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	Physician	pCO ₂	pO ₂	Qualify	Physician Impression
08-03-99 DX 54	Forehand	31.0 29.0+	58.0 56.0+	Yes Yes+	Arterial hypoxemia. (Dr. Michos found ABS technically acceptable, DX 54).
11-03-99 DX 56	Hippensteel	34.4	52.7	Yes	Moderate hypoxemia
07-14-00 CX 2	Forehand	32 29+	63 64+	Yes Yes+	Evidence of exercise-induced arterial hypoxemia.

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(c)(1), (2), or (3), or where pulmonary function tests and/or blood gas studies are

⁶ 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. § 718.204(c) permits the use of such studies to establish "total disability." It provides:

In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner's total disability: . . .

(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Forehand

Dr. Forehand, Board-certified in allergy, immunology, pediatrics and a B-reader, examined claimant on August 3, 1999. (DX 54). Claimant complained of progressively worsening shortness of breath and is unable to walk. Dr. Forehand reported arthrosclerotic cardiovascular disease. Claimant denied smoking and was employed in underground coal mining for 29 years, retiring in 1976. Upon physical examination, Dr. Forehand reported that claimant's speech was slow and forced, and he had no wheezes or crackles, and an x-ray showed mild diffuse reticular nodular disease, "1/0". Dr. Forehand performed an exercise arterial blood gas study, where claimant walked for one minute. Dr. Forehand opined "shortness of breath may very well be stemming from hypoxemia arising from progressively worsening coal workers' pneumoconiosis." Dr. Forehand prescribed oxygen.

Dr. Forehand examined claimant on July 14, 2000. (CX 1). Dr. Forehand previously examined claimant on June 27, 1994 and January 2, 1997. Dr. Forehand reported claimant worked in the underground mines from 1947 until 1976 as a roof bolter and coal loader. Dr. Forehand noted claimant smoked one pack of cigarettes per day for 15 years, quitting 30 years ago. Upon examination, Dr. Forehand noted fine end-inspiratory crackles at the lung bases and that claimant did not appear short of breath at rest. Dr. Forehand interpreted an x-ray as "p/p," "1/2." Dr. Forehand found no evidence of smoker's bronchitis. Dr. Forehand noted an arterial blood gas study was abnormal at rest and worsened with exercise. Dr. Forehand opined the study was specific for lung disease. Dr. Forehand opined that claimant's respiratory impairment is of such a degree that he would be unable to return to his last coal mining job. Dr. Forehand concluded that CWP is the predominant factor in claimant's respiratory impairment and Dr. Forehand found no evidence of smoker's bronchitis.

On July 18, 2000, Dr. Forehand reported scattered inspiratory crackles and no wheezes. Dr. Forehand diagnosed CWP and oxygen dependancy. (CX 2).

Dr. Hippensteel

Dr. Hippensteel, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, issued a report dated November 29, 1999, based on an examination of the claimant. (DX 56). Dr. Hippensteel reported claimant worked 29 years in the underground mines with his last job as a roof bolter. Claimant smoked one pack of cigarettes per day from age 18 until 1970. Dr. Hippensteel reported claimant was in a wheel chair and could only walk ten feet before becoming short of breath. Claimant has been on oxygen since August of 1999. Upon physical examination, Dr.

Hippensteel reported evidence of previous left carotid surgery, poor memory, and scattered rales in the lung bases. Dr. Hippensteel reported claimant was able to walk a few steps, but was not a candidate for exercise test because of his severe weakness with walking.

Dr. Hippensteel reported a chest x-ray was consistent with pneumoconiosis, "1/1" and p/q opacities in all lung zones. Dr. Hippensteel noted the pulmonary function tests were incomplete and the lung volume and diffusion are not likely to be accurate. Dr. Hippensteel found claimant's arterial blood gases showed moderate hypoxemia and the carboxyhemoglobin level was normal. Dr. Hippensteel concluded that the claimant has simple CWP without any ventilatory abnormality. Dr. Hippensteel opined the claimant has hypoxemia with basilar lung congestion and found incomplete evidence to decide causation. Dr. Hippensteel opined that claimant was impaired by mini strokes, high blood pressure, heart problems, and cholesterol. Dr. Hippensteel explained that the non-pulmonary problems can impair oxygenation and shortness of breath.

After reviewing claimant's medical records, Dr. Hippensteel opined that claimant has radiographic evidence of CWP and does not have a permanent ventilatory or gas exchange impairment from the CWP. Dr. Hippensteel explained the transient changes in gas exchange are not explained by CWP, because CWP causes a fixed impairment. Dr. Hippensteel found no effect on gas exchange due to CWP. Dr. Hippensteel opined that claimant was disabled due to his other medical problems unrelated to coal dust exposure. Dr. Hippensteel found no evidence that claimant's smoking history caused any permanent pulmonary impairment.

Dr. Hippensteel testified at deposition on July 24, 2000. (EX 10). Dr. Hippensteel examined claimant on November 3, 1999. (Dep. 8). Dr. Hippensteel reported that claimant worked as a roof bolter and would have to perform some heavy manual labor. (Dep. 10). Dr. Hippensteel testified that claimant was taking medication for high blood pressure, cholesterol and his heart. Claimant had a history of mini-strokes, which worsened his memory function, and carotid artery surgery. (Dep. 11-12). Dr. Hippensteel observed scattered rales in claimant's lungs. (Dep. 12). Dr. Hippensteel diagnosed simple pneumoconiosis by chest x-ray. Based on a pulmonary function study, Dr. Hippensteel found no obstruction or restriction and noted the MVV was not valid. Dr. Hippensteel opined that the spirometry conducted by Dr. Forehand revealed normal lung capacity, volumes, and diffusion capacity.

Dr. Hippensteel opined that the test performed in August of 1999 by Dr. Forehand was not a true exercise study because claimant did not have a significant elevation in his heart rate with exercise. (Dep. 15). Dr. Hippensteel opined that claimant had mild to moderate hypoxemia. (Dep. 16). Dr. Hippensteel does not believe claimant's hypoxemia is a result of CWP. Dr. Hippensteel opined that in CWP, he would expect worsening hypoxemia with exercise. (Dep. 20). Dr. Hippensteel opined that claimant's hypoxemia is connected with his cardiovascular problems, hypertension, and strokes. (Dep. 21-23). Dr. Hippensteel opined that claimant's hypoxemia is not caused by CWP because claimant has a normal diffusion capacity and ventilatory capacity. Dr. Hippensteel opined that coal dust

exposure did not aggravate claimant's disability. (Dep. 25). Dr. Hippensteel opined that claimant is disabled as a whole man, due to his strokes, hypertension, and gas exchange. (Dep. 25-26). Dr. Hippensteel opined that claimant does not have intrinsic impairment in his lungs from CWP or from cigarette smoking. (Dep. 26-27).

Dr. Hippensteel believes claimant's hypoxemia is due to a combination of neurologic, i.e. strokes, and cardiovascular component. (Dep. 31-32). Dr. Hippensteel agreed that simple pneumoconiosis can cause total pulmonary disability. (Dep. 41). Dr. Hippensteel opined that exercise arterial blood gas study was not valid because claimant was only exercised for one minute. (Dep. 43). However, the resting tests are still valid. (Dep. 44). Dr. Hippensteel opined that claimant does not have silicosis because claimant does not exhibit signs of a restrictive disease and does not have a ventilatory impairment. (Dep. 48).

Dr. Hippensteel submitted a supplemental report dated August 14, 2000. (EX 13). Dr. Hippensteel reviewed additional medical records and opined that his opinion remained unchanged. Dr. Hippensteel opined that a gas exchange impairment from pneumoconiosis is a fixed problem that can deteriorate with exercise. Dr. Hippensteel opined that variable chest congestion, his neurologic status, and cardiovascular problems, are sufficient to cause gas exchange impairment on a non-pulmonary basis.

Dr. Fino

Dr. Fino, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, issued a report dated February 15, 2000, based on a review of claimant's medical records. (EX 1). Dr. Fino noted claimant has developed significant hypoxia since 1997. Dr. Fino opined that the hypoxia cannot be attributed to his pneumoconiosis and noted that it is unusual for pneumoconiosis to be progressive. Dr. Fino opined that silicosis may be a progressive disease in a small percentage of miners after coal mine dust exposure ends. However, Dr. Fino noted that the literature does not support the statement that CWP is progressive absent further exposure. Dr. Fino reported, "there are no studies that show progressive impairment in miners who have left the mines." Dr. Fino opined that if pneumoconiosis has progressed to cause such a degree of hypoxia, then it should be associated with a worsening of the chest x-ray, worsening of spirometry and worsening of diffusing capacity. Dr. Fino noted that claimant's chest x-ray readings are unchanged and the spirometry and diffusion are normal. Therefore, Dr. Fino concluded that "it is not medically reasonable to opine that this man's pneumoconiosis accounts for any, or all, of the hypoxia." Dr. Fino opined that further testing of claimant's cardiac status is warranted as a cause of hypoxia and that his history of strokes puts him at risk of aspiration which can cause hypoxia.

Dr. Fino issued a supplemental report dated July 5, 2000. (EX 6). After reviewing additional records, Dr. Fino did not change his opinion. Dr. Fino found claimant suffered from significant hypoxia which is not attributable to pneumoconiosis. Dr. Fino issued a supplemental report dated August 10,

2000. (EX 12). Based on a review of additional medical evidence, Dr. Fino opined that claimant's hypoxia is not due to pneumoconiosis.

Dr. Tuteur

Dr. Tuteur, Board-certified in internal medicine with a subspecialty in pulmonary diseases, reviewed claimant's medical records and submitted a report dated May 30, 2000. (EX 3). Dr. Tuteur reported claimant worked in the coal mines for thirty years as a cutting machine

operator, loading machine operator and his last job was as a stoker or roof bolter. Dr. Tuteur reported claimant smoked from his teens until the 1970's for an approximate 25 pack-years history.

Dr. Tuteur concluded that there is sufficient objective evidence to justify a diagnosis of radiographically significant CWP. Dr. Tuteur opined that claimant's CWP is of insufficient profusion and severity to cause clinical symptoms, physical examination abnormalities, and impairment of pulmonary function. Dr. Tuteur noted claimant's history of hypertension, musculoskeletal problems and mini-strokes. Dr. Tuteur noted that as early as 1984 claimant had intermittent resting hypoxemia but that in 1997, the arterial blood gases were within normal limits. Dr. Tuteur opined that claimant's pulmonary status has remained stable and within normal limits. Dr. Tuteur opined that the mild resting impairment of gas exchange is not a result of a pulmonary process related to the inhalation of coal mine dust. It may reflect very mild small airways disease, but most likely represent suboptimal bellows function due to musculoskeletal impairment of diaphragm and thoracic cage resulting in shallow more rapid breathing.

Dr. Tuteur reported that claimant does not have persistent significant impairment of pulmonary function and that most of the pulmonary function studies were invalid. Because no persistent impairment of pulmonary function is documented, Dr. Tuteur opined that claimant does not have impairment of pulmonary function that can be attributed to CWP. Dr. Tuteur attributes the intermittent impairment of arterial blood gases to claimant's past cigarette smoking history. Dr. Tuteur found claimant totally and permanently disabled due to musculoskeletal problems, intermittent syncope, and progressive cerebral vascular insufficiency. Dr. Tuteur concluded that although the claimant has radiographically significant CWP, the disease has not influenced his health status in any way.

Dr. Tuteur submitted a supplemental report dated August 4, 2000. (EX 11). Dr. Tuteur reported claimant smoked one pack of cigarettes per day for approximately twenty-five years. Dr. Tuteur noted claimant has musculoskeletal problems, organic heart disease, hypertensive heart disease complicated by syncopal episodes. Claimant experiences exercise intolerance, intermittent cough, wheezing, and chest discomfort. Dr. Tuteur opined that claimant has mild interstitial pulmonary process unassociated with impairment of pulmonary function. Dr. Tuteur opined that claimant's health has deteriorated over the last ten years due to cerebral vascular insufficiency resulting in cerebral vascular

accident, contributed to by his blood pressure. Dr. Tuteur attributes claimant's breathlessness to his musculoskeletal disorder and strokes. Dr. Tuteur noted that physiologically significant CWP would be expected to produce a restrictive ventilatory defect and impairment of gas exchange.

Dr. Tuteur concluded that although claimant has radiographically significant CWP, it is without clinical symptomatology, without abnormality on physical examination, and without measurable physiologic impairment of lung function. Dr. Tuteur found claimant totally disabled due to chronic low back syndrome, suboptimally controlled hypertension, anti-hypertensive medication and cerebral vascular accidents, strokes. Dr. Tuteur opined claimant's disability is not a result of the inhalation of coal mine dust. Claimant does not have any pulmonary or respiratory impairment due to CWP.

Dr. Dahhan

Dr. Dahhan, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, reviewed claimant's medical records and submitted a report dated June 12, 2000. (EX 4). Based on a review of the medical records, Dr. Dahhan concluded that claimant has simple CWP. Dr. Dahhan stated there were no findings to justify a diagnosis of complicated CWP and that claimant has normal spirometry, lung volumes and diffusion capacity, which rules out any intrinsic lung impairment. Dr. Dahhan opined that the alteration in blood gas exchange is not due to CWP. Dr. Dahhan explained "it is quite possible that he is developing congestive heart failure due to coronary artery disease, which is known to cause such hypoxemia." Dr. Dahhan opined the evidence does not support a diagnosis of cor pulmonale. Dr. Dahhan concluded that from a pulmonary standpoint, claimant has no evidence of impairment and/or disability secondary to simple CWP, and found he retains the physiological capacity to return to his previous coal mining work.

Dr. Dahhan issued a supplemental report dated August 3, 2000, based on a review of claimant's medical records. (EX 11). Dr. Dahhan concluded that claimant has radiological findings sufficient to diagnose simple CWP and has no findings of complicated CWP. Dr. Dahhan reported that claimant has developed significant hypoxemia, which was not present prior to his stroke. Dr. Dahhan opined that the hypoxemia is not due to coal dust exposure or simple CWP. Dr. Dahhan concluded that claimant has normal respiratory mechanics indicating that he retains the physiological capacity to continue his previous coal mining work. Dr. Dahhan diagnosed hypertension, old CVA, and hyperlipidemia, which are unrelated to coal dust exposure.

Dr. Iosif

Dr. Iosif, Board-certified in internal medicine with a subspecialty in pulmonary diseases, issued a report based on a review of claimant's medical records dated June 29, 2000. (EX 5). Dr. Iosif previously evaluated claimant on June 24, 1997. In his previous report, Dr. Iosif diagnosed simple CWP and noted physical findings that indicated COPD. Dr. Iosif noted claimant stopped smoking in 1970. Dr. Iosif concluded that claimant has CWP and that the disease has not progressed. Claimant's

pulmonary function studies have been normal. Dr. Iosif noted that claimant's CWP has not progressed and therefore, CWP is not the cause of claimant's recent hypoxemia. Dr. Iosif stated, "it is not medically reasonable from a pulmonary pathophysiologic standpoint to link the radiographic abnormalities of simple coal workers' pneumoconiosis seen in this case, which have been stable, to the late development of hypoxemia in the absence of deteriorations of the spirometric indices, diffusing capacity or static lung volumes." Dr. Iosif stated that a possible explanation for the development of hypoxemia could be due to low cardiac output. Dr. Iosif noted claimant suffers from hypertension and cerebrovascular infarctions and left carotid endarterectomy. Dr. Iosif opined that possibly ischemic or hypertensive cardiomyopathy caused diminished cardiac output and lead to the indirect development of hypoxemia. Dr. Iosif concluded that claimant was totally and irreversibly disabled as a result of non-occupational neuropsychiatric ailments.

Dr. Iosif issued a supplemental report dated August 3, 2000, based on a review of claimant's medical records. (EX 11). Dr. Iosif opined that claimant has radiographic evidence of CWP. Dr. Iosif stated that he has "difficulty accepting this condition [CWP] as the cause for his exercise related derangement in oxygenation when all and every aspect of his pulmonary function tests including the assessment of gas exchange capabilities with the measurement of diffusing-capacity have been consistently normal." Dr. Iosif recommended that claimant undergo a full cardio-pulmonary stress test.

Dr. Castle

Dr. Castle, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, submitted a report dated July 6, 2000, based on a review of additional medical records. (EX 7). Dr. Castle opined that claimant has radiographic evidence of simple CWP, which has not changed since 1997. Dr. Castle reported that claimant has developed significant hypoxemia which was not present in 1997. Prior to 1997, claimant had transient episodes of hypoxemia, which improved with exercise. Dr. Castle opined that hypoxemia caused by CWP is neither transient nor reversible with exercise or over time. Dr. Castle opined that the degree of hypoxemia which claimant has developed since 1997 is totally unrelated to his underlying CWP. Dr. Castle opined that claimant's hypoxemia is associated with nonpulmonary problems including cardiovascular disease and neurologic impairment. Dr. Castle noted that if claimant had a progression in CWP, he would have had a worsening of his chest x-rays, lung volumes, diffusing capacity or spirometry. Claimant had none of these findings. Dr. Castle opined that claimant is totally disabled due to his neurovascular abnormalities including cerebrovascular accident and "probable" cardiovascular disease, which are unrelated to coal dust exposure.

Dr. Castle testified at deposition on July 10, 2000. (EX 9). Dr. Castle evaluated claimant on September 11, 1997 and reviewed additional medical records and issued a supplemental report dated July 6, 2000. (Dep. 4). Dr. Castle interpreted the November 3, 1999 and August 3, 1999 x-rays as positive for pneumoconiosis. (Dep. 5-6). Dr. Castle opined that claimant's twenty-nine years of coal

mine employment is sufficient coal dust exposure to sustain a diagnosis of CWP by x-ray. (Dep. 7). Dr. Castle opined that the spirometry conducted by Dr. Forehand is not valid because of less than maximal effort and lack of reproducibility. However, Dr. Castle opined that the study was normal. (Dep. 8). Dr. Hippensteel's spirometry was invalid because of suboptimal effort, but the values were normal. (Dep. 9). Dr. Castle opined that claimant does not have a significant degree of emphysema as a result of smoking. (Dep. 10-11).

Claimant's arterial blood gas study in 1997 was normal. (Dep. 11). Dr. Castle noted a significant decline in claimant's arterial oxygen comparing the 1997 studies to the 1999 studies. (Dep. 11-12). Dr. Castle opined that Dr. Forehand's study is not sufficient to constitute an exercise study. Dr. Castle opined that there has not been a significant decline in claimant's pulmonary functional capacity since 1997. (Dep. 13). Dr. Castle opined that claimant's hypoxemia is unrelated to his pulmonary system and unrelated to CWP. Dr. Castle explained that if claimant's hypoxemia were related to CWP, claimant should have had a change in his pulmonary function studies and x-rays. (Dep. 14-15). Dr. Castle attributed claimant's hypoxemia to claimant's cerebral vascular disease and potentially his obesity. (Dep. 15). Dr. Castle explained claimant does not breathe normally due to his strokes and obesity, which results in under-ventilated lungs and hypoxemia. (Dep. 16). Dr. Castle opined that claimant has ventilation perfusion mismatching where he does not take deep breaths, and has collapse of some lung units, which results in the blood not obtaining enough oxygen. (Dep. 17-18).

Dr. Castle opined that claimant's CWP arose out of his thirty years of coal mine employment. Dr. Castle opined that from a pulmonary standpoint, claimant has the respiratory capacity to return to his last coal mine job. However, claimant is totally disabled as a whole person due to his severe cerebrovascular disease and multi-infarct dementia. Dr. Castle opined that CWP and coal dust exposure has not contributed to claimant's disability. (Dep. 20). Dr. Castle opined that claimant does not have any impairment related to his CWP and he does not have any physiologic functional abnormality related to CWP. (Dep. 21).

Dr. Castle submitted a report dated August 17, 2000, based on a review of additional medical evidence. (EX 14). Dr. Castle opined that claimant has radiographic evidence of simple CWP. Dr. Castle disagrees with Dr. Forehand's opinion that claimant has abnormal resting and exercise blood gases and that there is a significant change with exercise. Dr. Castle opined that the changes are not significantly different after exercise than the resting blood gas. Dr. Castle opined that claimant's ventilatory function is entirely normal. Dr. Castle noted a ventilation and perfusion mismatch related to previous cerebrovascular accident as well as his body habitus. Dr. Castle explained that claimant has an increase in pO₂ during recovery and the findings are consistent with an abnormality due to his ventilation perfusion mismatch related to multiple strokes and multi-infarct dementia. Dr. Castle explained that pulmonary abnormalities related to CWP do not have an increase in pO₂ after exercise. Dr. Castle concluded that claimant does not have any respiratory impairment or disability related to CWP. Dr. Castle opined that a variable degree of hypoxemia and improvement in hypoxemia, "is not something that is associated with a fixed pulmonary process such as coal workers' pneumoconiosis."

Dr. Castle testified at deposition on September 25, 2000. (EX 15). Dr. Castle found Dr. Forehand's pulmonary function study invalid. (Dep. 8). Dr. Castle opined the study invalid due to variable effort. Although Dr. Castle found the study invalid, he opined that claimant's best effort shows the study is "totally normal." (Dep. 10). Dr. Castle opined the pulmonary function demonstrated a mild degree of gas trapping and found the study indicated normal physiologic function of the lungs. (Dep. 23).

Dr. Castle analyzed the exercise arterial blood gas study performed by Dr. Forehand where claimant was exercised for three minutes. Dr. Castle found the exercise test valid because claimant had a significant increase in his heart rate. (Dep. 32). Dr. Castle opined the study showed mild chronic hyperventilation. Dr. Castle noted a mild degree of hypoxemia with the pO₂ at 63. After exercise, claimant's blood gases remained essentially unchanged and he did not have a decrease in pO₂. (Dep. 33). Dr. Castle noted on recovery, claimant had a mild degree of acidosis and the pO₂ rose, indicating claimant had a normal response. Dr. Castle opined that claimant is able to oxygenate his blood and has a normal response at the end of the recovery period. (Dep. 34). Dr. Castle opined that considering the claimant's age and the altitude at which the test was performed, claimant had normal blood gases. (Dep. 34).⁷ Dr. Castle opined that claimant's minimal hypoxemia is not caused by an intrinsic pulmonary problem. (Dep. 35).

Dr. Castle noted that in 1999, claimant's pO₂ level was 58, 56, and 53. In subsequent studies, claimant has pO₂ values in the 60 range. Dr. Castle opined that he would not expect the variable degree of abnormality in an impairment caused by coal dust exposure. (Dep. 36). Dr. Castle opined that if CWP was the cause of claimant's hypoxemia, he would not expect to see variability or improvement and would expect a fall in pO₂ with exercise. (Dep. 36-37). Dr. Castle noted the exercise arterial blood gas study showed claimant is deconditioned, with minimal physical reserve, and claimant did not developed significant hypoxemia during exercise. Dr. Castle found claimant suffered from problems, fatigue, rapid heart rate, which are unrelated to his pulmonary system. (Dep. 41).

Dr. Castle opined that claimant has CWP, but does not have any pulmonary or respiratory impairment and retains the respiratory capacity to perform his last coal mine employment. (Dep. 43-44). Dr. Castle opined that, as a whole person, claimant is disabled due to severe cerebrovascular disease with multi-infarct dimension, a result of atherosclerotic disease on the vascular system to his brain. (Dep. 44).

Dr. Castle last examined the claimant in 1997. (Dep. 56). Dr. Castle agreed that the inhalation of coal dust can cause shortness of breath. Dr. Castle opined that the claimant does not exhibit evidence of any pulmonary impairment. (Dep. 60). Dr. Castle found claimant had evidence of severe

⁷ Dr. Castle does not believe the elevation in Richlands, where arterial blood gas studies were performed, is higher than 3,000 feet above sea level. (Dep. 48).

cerebrovascular disease which can result in shortness of breath. (Dep. 61). Dr. Castle did not find evidence that coal dust exposure irritated claimant's bronchial tubes. (Dep. 62-63). Dr. Castle did not diagnose claimant with silicosis and does not believe silica dust caused claimant's blood gas results. (Dep. 63-64).

Dr. Castle noted that Dr. Forehand observed fine end inspiratory crackles at the lung bases. Dr. Castle opined that fine end inspiratory crackles are at the small airway level. (Dep. 70-71). Dr. Castle did not observe any irregular opacities on claimant's x-ray. Dr. Castle found rounded opacities on the x-ray which are consistent with CWP. (Dep. 73). Dr. Castle opined that claimant has not lost any pulmonary reserve based on his pulmonary function studies. (Dep. 83-84). Dr. Castle stated that he does not use a blood gas study alone to determine pulmonary impairment because a blood gas abnormality may be due to other factors other than the lungs. (Dep. 85). Dr. Castle could not define a circumstance where a patient with a normal pulmonary function test and an abnormal blood gas test would have a pulmonary disability. (Dep. 86). Dr. Castle opined that claimant's stroke affected his brain but not his lungs. (Dep. 92). Dr. Castle opined that the variability in claimant's arterial blood gas studies is more consistent with ventilation perfusion mismatching as opposed to a physiologic impairment related to CWP which is irreversible. (Dep. 93). Dr. Castle opined that he would not expect a person with CWP to have the degree of variation that claimant has exhibited. (Dep. 93-94).

Dr. Renn

Dr. Renn, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, reviewed claimant's medical records and issued a report dated July 16, 2000. (EX 8). Dr. Renn concluded that claimant suffers from simple CWP with no physiologic impairment and normal ventilatory function. Dr. Renn opined that claimant's hypoxemia resulted from shunt or diminished cardiac output. Dr. Renn also diagnosed systemic hypertension, residual of old cerebral vascular accidents, arteriosclerotic cerebral vascular disease, degenerative joint disease and hypercholesterolemia. When considering only claimant's respiratory system, Dr. Renn opined that claimant is not totally and permanently impaired to the extent that he would be unable to perform his last coal mining job as a stoker. As a whole man, claimant is totally disabled. Dr. Renn opined that the degree of CWP is not etiologically the cause of his hypoxemia. Dr. Renn noted that claimant was last exposed to coal mine dust in 1997 and his hypoxemia did not develop until July of 1997. Dr. Renn explained that claimant has normal dynamic and static lung function and has no diffusion abnormality. Dr. Renn noted that shunt as a cause for claimant's hypoxemia has not been explored. Dr. Renn opined that "it is possible" that diminished cardiac output could be etiologically responsible for at least portion of claimant's hypoxemia.

Dr. Renn issued a supplemental report dated August 9, 2000. (EX 12). Dr. Renn noted that claimant has normal dynamic and static ventilatory function and diffusing capacity. Dr. Renn opined that with a normal diffusing capacity, claimant would not be expected to develop exercise-induced

hypoxemia. Dr. Renn opined that the resting and exercise arterial blood gas studies performed by Dr. Forehand are normal for claimant's age. Dr. Renn opined that the additional medical records do not alter his opinion.

III. Hospital Records & Physician Office Notes

On May 23, 2000, Dr. Motos reported that claimant's chest and lungs were clear. Dr. Motos diagnosed hypertension, hyperlipidemia, status post cerebrovascular accident, and dermatitis. On March 6, 2000, Dr. Motos reported rhonchi. On January 6, 2000, Dr. Motos reported scattered wheezes and rhonchi and diagnosed acute bronchitis. On October 27, 1999, Dr. Motos reported clear chest and lungs and diagnosed COPD, hypertension, hyperlipidemia and seizure disorder.

Claimant submitted an excerpt from the Dictionary of Occupational Title, Vol.II, Forth Edition, 1991, which describes the "stope miner" job to require very heavy work, which exceeds 100 pounds occasionally and 50 pounds frequently and must move 20 pounds or more constantly. (CX 3).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). See *Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997).

Since this is the claimant's fourth claim for benefits, he must initially show that there has been a material change of conditions.⁸ To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial. *Lisa Lee Mines v. Director*,

⁸ Section 725.309(d) provides, in pertinent part:

In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

OWCP, 86 F.3d 1358 (4th Cir. 1996) (*en banc*); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995). See *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change.⁹ The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits.

Sharondale Corp. v. Ross, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F. 3d 308 (3rd Cir. 1995). After reviewing the newly submitted evidence, I find claimant has established a material change in condition.

Under 20 C.F.R. § 725.310, a modification petition may be based upon a mistake of fact or a change in conditions. In determining whether a mistake of fact has occurred, the Administrative Law Judge is not limited to a consideration of newly submitted evidence. All evidence of record may be reviewed to determine whether a mistake of fact was previously made. *O’Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256, 92 S.Ct. 405, 407, 30 L.Ed.2d 424 (1971)(per curiam)(decided under Longshore and Harbor Workers’ Compensation Act). The Administrative Law Judge has “broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence previously submitted.”¹⁰ *O’Keefe*, 404 U.S. 254 at 257; *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1364 (4th Cir. 1996)(*en banc*), quoting *Jessee v. Director, OWCP*, 5 F.3d 723, 724 (4th Cir. 1993). Therefore, a complete review of the record will be conducted to determine whether a mistake of fact exists. A review of the record does not show that there has been a mistake of fact.

To assess whether a change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994)(“Change in conditions” not established where the existence of pneumoconiosis by chest x-ray was demonstrated in the original claim and the claimant merely submitted additional positive x-ray readings on modification); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); and, *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff’d on recon.*, 16 B.L.R. 1-71 (1992). After a review of

⁹ Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it “differ[s] qualitatively” from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n.11.

¹⁰ The United States Court of Appeals for the Fourth Circuit reiterated its well-established modification standard in *Consolidation Coal Co. v. Borda*, ___ F.3d ___, 21 B.L.R. ___, No. 98-1109 (4th Cir. March 15, 1999), holding that “a request for modification need not meet formal criteria,” and “there is no need for a smoking-gun factual error, changed conditions, or startling new evidence.” *Id.* at 4.

the record, I find claimant has established a change in conditions.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.”¹¹ 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to “coal workers’ pneumoconiosis,” but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201. The term “arising out of coal mine employment” is defined as including “any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”

“ . . . [T]his broad definition ‘effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.’” *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) citing, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for “complicated pneumoconiosis” found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers’ pneumoconiosis.

¹¹ Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3^d Cir. 1995) at 314-315.

The parties stipulate to the existence of pneumoconiosis and I find the claimant has met his burden of proof in establishing the existence of pneumoconiosis. (TR 8-9).

C. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. The parties stipulate to and I find that claimant's pneumoconiosis arose out of coal mine employment. (TR 9).

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(c)(1) through (c)(5) set forth criteria to establish total disability: (1) pulmonary function studies with qualifying values; (2) blood gas studies with qualifying values; (3) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and (5) lay testimony.¹² Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with

¹² 20 C.F.R. § 718.204(c). In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

nonrespiratory and nonpulmonary impairments.” Even if it is determined that claimant suffers from a totally disabling respiratory condition, he “will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems.” *Id.* at 534.

Section 718.204(c)(3) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(c)(5) is not applicable because it only applies to a survivor’s claim in the absence of medical evidence.

Section 718.204(c)(1) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). Eight pulmonary function studies were performed between 1977 and 1990. Of the eight studies, only two produced qualifying results. However, as Judge Amery noted, the two studies which produced qualifying results were declared invalid by several doctors. There were three pulmonary function studies performed in 1997, none of which produced qualifying results. Three studies were submitted in conjunction with the most recent modification claim. Although there are conflicting reports on the validity of the recent pulmonary function studies, none of the studies produced qualifying results. Considering the newly submitted evidence in conjunction with the previously submitted evidence, a majority of the studies produced non-qualifying results. Therefore, I find claimant has not established the existence of total disability under section 718.204(c)(1).

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(c)(2). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). Five arterial blood gas studies were submitted between January of 1983 and May of 1990. Of the five studies, only the April 24, 1984 study produced qualifying results. Three studies were performed in 1997. The May 7, 1997 study produced qualifying results. However, this study was performed while the claimant was hospitalized and on oxygen. After reviewing the old medical evidence of record, I find that claimant did not have sufficient evidence to show total disability from 1983 through 1997. However, the most recent arterial blood gas studies, dated August 3, 1999, November 3, 1999, and July 14, 2000, all produced qualifying results. Therefore, based on the most recent qualifying arterial blood gas studies, I find claimant has established a material change in conditions and total disability under § 718.204(c)(2).

Finally, total disability may be demonstrated, under § 718.204(c)(1), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner’s respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, “. . . all the evidence relevant to the question of

total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element.” *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant’s usual coal mine employment with a physician’s assessment of the claimant’s respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going

forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

In the previous denial of benefits, Judge Amery and Judge Sarno found claimant did not establish total disability. After analyzing the previously submitted evidence, I find Judge Amery and Judge Sarno did not make a mistake of fact.

In his 1977 report Dr. Hatfield diagnosed pneumoconiosis but found little or no impairment. In 1982, Dr. Javed opined that claimant had severe COPD and found claimant had severe difficulty in breathing on mild exertion. Dr. Berry found claimant disabled since July of 1976 due to bronchitis, asthma, and black lung. In 1984, Dr. Abernathy diagnosed CWP and obstructive emphysema. Dr. Abernathy opined that claimant symptoms were caused by cigarette smoking and that CWP did not produce any of his symptoms. Dr. Abernathy found some pulmonary impairment, but opined that claimant was able to continue in his occupation as a roof bolter. In 1990, Dr. Abernathy found claimant had the respiratory capacity to perform his last job. In 1986, Dr. Kanwal diagnosed COPD and pneumoconiosis. Dr. Kanwal found claimant was very short of breath. In 1986, Dr. Renn diagnosed simple CWP and found claimant was not totally disabled from his last coal mine employment when considering only claimant’s respiratory symptoms. In a report dated November 17, 1986, Dr. Kress did not find claimant’s respiratory impairment sufficient to preclude him from performing his job as a roof bolter. In 1990, Dr. Dahhan found claimant retained the physiological capacity, from a respiratory standpoint, to perform his last coal mining employment. In 1990, Dr. Tuteur opined that claimant’s CWP is not causing symptoms or physiologic impairment. Dr. Tuteur found claimant totally disabled due to his musculoskeletal problems. Also in 1990, Dr. Fino opined that claimant does not have any pulmonary or respiratory impairment due to CWP or any lung disease.

I find Judge Amery did not make a mistake of fact in his prior determination. I agree with Judge Amery’s findings and adopt them as my own. Judge Amery noted that only Dr. Berry determined that claimant was disabled and unable to work due to his respiratory condition. Judge Amery also noted that Dr. Javed and Dr. Kanwals’ opinions may be construed as finding claimant was unable to perform his last coal mine employment. Judge Amery credited seven doctors, Drs. Hatfield, Abernathy, Renn, Kress, Dahhan, Tuteur and Fino, all found claimant was not disabled from a

respiratory standpoint and could return to coal mining job.

I also find that Judge Sarno did not make a mistake of fact in finding claimant was not totally disabled due to pneumoconiosis. In January of 1997, Dr. Forehand diagnosed simple CWP, but found no evidence of respiratory impairment. Dr. Iosif submitted a report dated July 16, 1997, and found no significant evidence of respiratory function impairment. On July 29, 1997, Dr. Castle found claimant permanently and totally disabled due to stroke, but found no respiratory impairment. Dr. Dahhan issued reports dated September 22, 1997, October 17, 1997 and November 7, 1997. Dr. Dahhan found claimant did not suffer from any respiratory impairment and that he retain the pulmonary capacity to continue his previous coal mining work. Dr. Dahhan found claimant totally disabled due to a stroke, hypertension and arthritis. Dr. Fino issued reports dated October 13, 1997, October 31, 1997 and November 19, 1997. Dr. Fino found no respiratory impairment and opined claimant was not totally disabled from returning to his last coal mining job. None of the above physicians found claimant had a total respiratory disability. Therefore, I find Judge Sarno did not make a mistake of fact.

Eight physicians submitted opinions in connection with the most recent modification claim. Dr. Forehand, Board-certified in allergy, immunology, and pediatrics, found claimant suffered from a respiratory impairment which is sufficient to keep him from performing his last coal mine job. Dr. Forehand opined that CWP is a predominant factor in claimant's respiratory impairment. Dr. Hippensteel, Board-certified in internal medicine with a subspecialty in pulmonary diseases, opined that claimant has CWP, but does not suffer a permanent ventilatory or gas exchange impairment from the disease. Dr. Hippensteel opined that claimant is disabled as a whole man due to strokes, hypertension, and gas exchange. Dr. Fino, Board-certified in internal medicine with a subspecialty in pulmonary diseases, noted claimant has developed significant hypoxia since 1997, but that the hypoxia is not due to CWP. Dr. Fino did not render an opinion on total disability. Dr. Tuteur, Board-certified in internal medicine with a subspecialty in pulmonary diseases, found claimant totally and permanently disabled due to musculoskeletal problems, intermittent syncope, and progressive cerebral vascular insufficiency, or strokes. Dr. Tuteur opined that claimant did not have any respiratory impairment due to CWP. Dr. Dahhan, Board-certified in internal medicine with a subspecialty in pulmonary diseases, opined that claimant does not exhibit any evidence of impairment or disability secondary to CWP and from a respiratory standpoint is able return to his last coal mine job. Dr. Iosif, Board-certified in internal medicine with a subspecialty in pulmonary diseases, opined that claimant is totally disabled as a result of non-occupational neuropsychiatric ailments. Dr. Castle, Board-certified in internal medicine with a subspecialty in pulmonary diseases, found claimant has the respiratory capacity to return to his last coal mine job. Dr. Castle opined claimant is totally disabled due to neurovascular abnormalities and strokes. Dr. Renn, Board-certified in internal medicine with a subspecialty in pulmonary diseases, opined that from a respiratory standpoint, claimant is not totally and permanently impaired and would be able to perform his last coal mine employment.

Of the eight physician submitted reports, only Dr. Forehand found claimant had a total respiratory disability. I afford more weight to the better qualified physicians, Drs. Hippensteel, Tuteur,

Dahhan, Iosif, Castle and Renn, all are Board-certified in internal medicine with a subspecialty in pulmonary diseases. These physicians did not find a totally disabling respiratory impairment, although they found claimant disabled due to other non-occupational causes. Because Dr. Forehand is less qualified, I afford his opinion less weight. Therefore after analyzing all of the evidence of record, I find the physicians' reports insufficient to establish a total respiratory impairment under § 718.204(c)(1).

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to walk short distances or lift, I find he is incapable of performing his prior coal mine employment.

Based on the most recent qualifying arterial blood gas studies, I find the claimant has met his burden of proof in establishing the existence of total disability. Analyzing the physicians' reports, I also find claimant is totally disabled as a whole man due to conditions unrelated to coal dust exposure. However, as discussed below, claimant has not established that pneumoconiosis is a contributing cause of his total disability.

E. Cause of total disability¹³

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.¹⁴ *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.* (So, one whose disability is only 10%

¹³ *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

¹⁴ *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." *Id.*

attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability). The fact that a physician does not explain how he could distinguish between disability due to coal mining and cigarette smoking or refer to evidence which supports his total disability opinion, may make his opinion “unreasoned.” *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59 (1984).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*,

917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).

As discussed above, I found the previously submitted evidence, dated 1977 through 1997, was insufficient to establish claimant had a respiratory impairment. Because I found the newly submitted evidence, arterial blood gas studies, established claimant is totally disabled, I will analyze whether the newly submitted evidence is sufficient to establish that CWP contributed to claimant’s total disability. Of the eight physicians submitting reports in connection with the most recent modification claim, only Dr. Forehand opined that CWP is a predominant factor in claimant’s respiratory impairment. However, as discussed above, I afford Dr. Forehand’s opinion less weight because he is less qualified, with no specialty in pulmonary medicine. Drs. Hippensteel, Fino, Tuteur, Dahhan, Iosif, Castle, and Renn are all Board-certified in internal medicine with a subspecialty in pulmonary diseases. None of these more qualified physicians found CWP contributed to claimant’s disability. Drs. Hippensteel, Fino, Tuteur, Dahhan, and Castle attributed claimant’s hypoxemia primarily to strokes, and other non-occupational problems. Dr. Castle explained that claimant’s hypoxemia is related to his strokes because claimant does not breathe normally due to his strokes which results in under-ventilated lungs and hypoxemia. Dr. Iosif attributed claimant’s hypoxemia to low cardiac output, and possible ischemic or hypertensive cardiomyopathy. Dr. Renn attributed claimant’s hypoxemia to shunt or diminished cardiac output. I do not afford Dr. Motos’ opinion much weight because he did not render an opinion on the cause of claimant’s disability. Because the majority of well-qualified physicians did not find that CWP contributed to claimant’s disability, I find the evidence insufficient to establish that pneumoconiosis is a contributing cause of the claimant’s total disability.

ATTORNEY FEES

The award of attorney’s fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has established that a material change in conditions has taken place since the previous denial, because he is now has a total respiratory disability. The claimant has not established a mistake of fact. The claimant has pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis arose out of his coal mine employment. The claimant is totally disabled. His total disability is not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER

It is ordered that the claim of LUTHER A. BLANKENSHIP for benefits under the Black Lung Benefits Act is hereby DENIED.

RICHARD A. MORGAN
Administrative Law Judge

RAM:EAS:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

